

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024282

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3176

STATE FILE NUMBER

FILED JUN 17 1963

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
Carl H. Brust
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN Kansas City	
Length of stay in 1b 40 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) TRINITY LUTHERAN HOSP		d. STREET ADDRESS (If outside, give location) 4009 E. 106 TERRACE	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK H EATHERTON		4. DATE OF DEATH Month JUNE Day 4 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KANSAS CITY POWER & LIGHT		10b. KIND OF BUSINESS OR INDUSTRY SYSTEM OPERATOR	
11. BIRTHPLACE (City and state or country) KEYTESVILLE, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME BUSHROD EATHERTON		13b. MOTHER'S MAIDEN NAME EVALENA EIDSON	
14. NAME OF HUSBAND OR WIFE LENA EATHERTON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT 4009 E. 106 TERRACE, MRS. LENA EATHERTON	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5-2-63	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) end acute leukemia		PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Abdomen struck by a stone thrown up by a power lawn mower	
20c. TIME OF INJURY Hour 2:00 a.m. Month May Day 13 Year 63	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory	20f. CITY, TOWN, OR LOCATION Kansas City
21. I attended the deceased from May 13-63 to June 4-63 and last saw him alive on June 4-63 Death occurred at 5:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22. ADDRESS 106014th St K.C. Mo	
22a. SIGNATURE Carl H. Brust M.D. (Degree or title)		22c. DATE SIGNED 6-5-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 7, 1963	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMERS SONS, K.C., MO.		25. DATE RECD. BY LOCAL REG. 6-5-63	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

Dr. Carl Henry Bruest
106 West 14th Street - R. C. Bauer & Light Body - Medical Clinic
Room 718
2:00-5:00 PM
0 - 0 - 0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.